Substance Abuse and Mental Health Services Administration

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Behavioral Health is Essential To Health

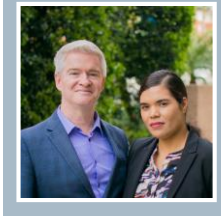
Prevention Works

Treatment is Effective

People Recover

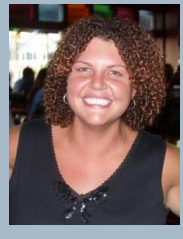
SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Good Medicine: Assessing and Adapting Medication Adherence Strategies to the Needs of PLWH, People At-Risk, and Living with Mental and Substance Use Disorders



Thomas Donohoe, M.B.A.
Professor of Family Medicine, David Geffen School of Medicine at UCLA
Director, Los Angeles Region Pacific AIDS Education and Training Center (LA PAETC)
Associate Director, UCLA Center for Health Promotion and Disease Prevention

Sandra Cuevas, B.A.
Project Coordinator
Los Angeles Region Pacific AIDS Education and Training Center (LA PAETC)



Nicole Proviano, R.N., M.S.
Director of Nursing
COPE Program Manager
Brandywine Counseling & Community Services

Members of Shared Action [HD]

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Slides for today's webinar are available on the CIHS website at:

http://www.integration.samhsa.gov/mai-coc-grantees-online-community/webinars

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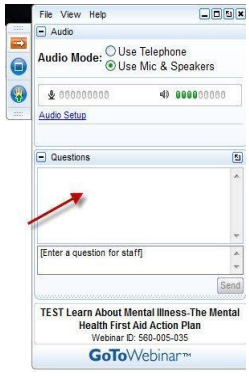
How to ask a question during the webinar



If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**

THIS WEBINAR IS BEING RECORDED

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Disclaimer:

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Learning Objectives

At the end of this session, grantees will be able to:

- Discuss the importance of adherence involving, in some cases, multiple medications and multiple co-morbidities in PLWHA
- Understand the most common reasons patients do not adhere to treatment regimens
- Identify important health, social and economic system factors impacting adherence
- Identify patient/provider related factors impacting adherence
- Discuss strategies and interventions to address system barriers and client concerns

Disclosure

The faculty reported the following financial relationships or relationships they or their spouse/life partner have with commercial interests related to the content of this continuing education activity:

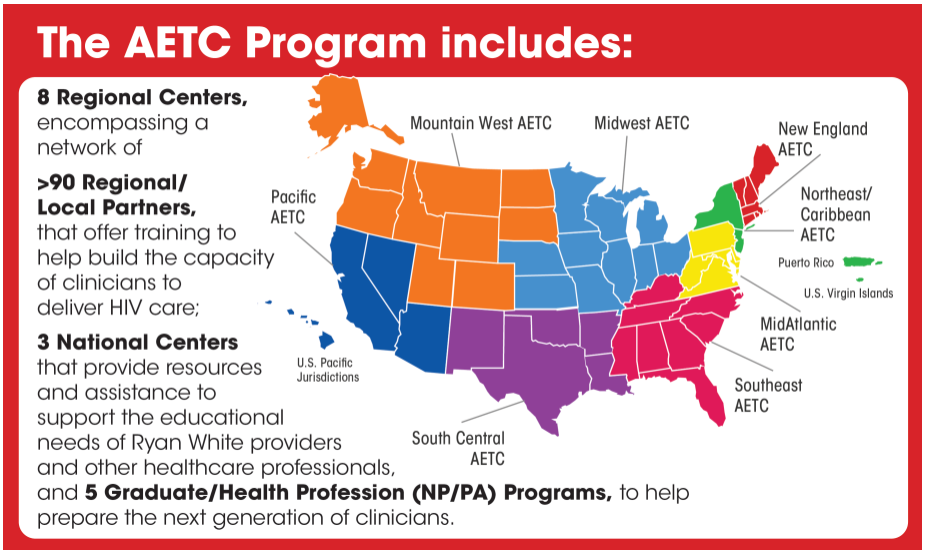
Tom Donohoe, M.B.A.: Nothing to disclose
Sandra Cuevas, B.A.: Nothing to disclose

Trainers

Tom Donohoe, M.B.A.
Professor of Family Medicine
Director, Los Angeles Region Pacific AIDS Education and Training Center
Associate Director, UCLA Center for Health Promotion and Disease Prevention

Sandra Cuevas, B.A.
Coordinator, Los Angeles Region Pacific AIDS Education and Training Center
David Geffen School of Medicine at UCLA
Members of SHARED ACTION HD

Nicole Proviano, R.N., M.S.
Director of Nursing
Brandywine Counseling & Community Services



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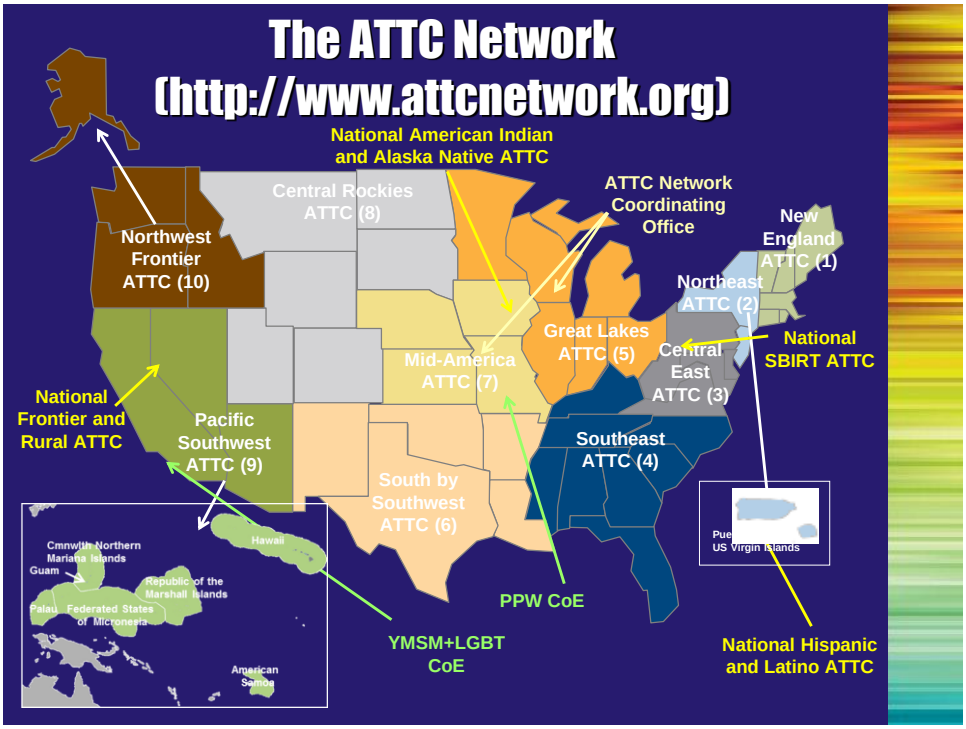

Webinar Overview

- What is medication adherence and why is it important to HIV treatment and prevention?
- CDC compendium of evidence-based interventions
- CDC medication adherence evidence-based interventions
- Why integration of behavioral health care and other providers is important to medication adherence

CASE: Dewayne

Dewayne is a 28 year old male, who is HIV positive, MSM and has been coming to your program for the past 2 years. When he arrived, he had been out of HIV care for 3 years, was quite ill and actively using drugs. Since that time, he has achieved an undetectable viral load and has been clean. He recently moved in with his partner of the past 6 months, who is HIV negative.

At his last visit, the case manager noted that Dewayne was upset that a "new medication" he was taking was causing him to have very strange dreams and sometimes these dreams reminded him about using. He said that therefore, he may have skipped "a dose or two." The case manager noted that Dewayne seemed depressed and appeared unshaven, which was unusual for him. He also missed his appointment with his nurse practitioner. When she contacted the pharmacy, she learned that Dewayne had not refilled his HIV medications last week. She called Dewayne on his cell and received an automatic message that it 'was disconnected'.

CASE: Dewayne (cont'd)

If Dewayne were a patient at your program, what resources would be available to him to help him maximize outcomes with his HIV and other treatment plans? Who would talk with him about medication adherence?

What are your top 2 concerns for Dewayne? Why?

How would you help address them in your role?

How can integrated care, including HIV medical care and substance use disorder treatment help Dewayne reconnect to care and thrive again?

Who do you think is MOST likely to talk with Dewayne about medication adherence?

1. Medical Clinician (M.D., NP, Nurse, etc.)
2. Case Manager
3. Substance Use Disorder Treatment Counselor
4. Mental Health Services Provider
5. Administrator, other

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Who do you think is LEAST likely to talk with Dewayne about medication adherence?

1. Medical Clinician (M.D., NP, Nurse, etc.)
2. Case Manager
3. Substance Use Disorder Treatment Counselor
4. Mental Health Services Provider
5. Administrator, other

HRSA Continuum of Engagement

Not in Care ⟷ **Fully engaged**

Unaware of HIV status	Aware of HIV status	May be receiving other medical care but not HIV care	Entered HIV medical care but dropped out	In and out of HIV care or infrequent user	Fully engaged in HIV medical care

What about migrants/highly mobile populations?

Source: Cheever. Clin Infect Dis 2007;44:1500-1502

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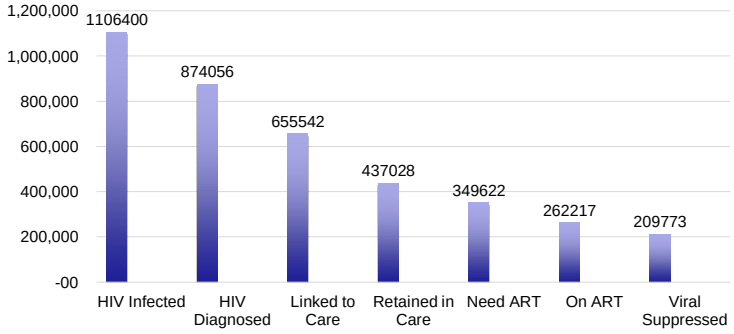
HIV Treatment Cascade



Gardner, E., et al. (2010). The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. *Clin Infect Dis.* 52(6):793-800

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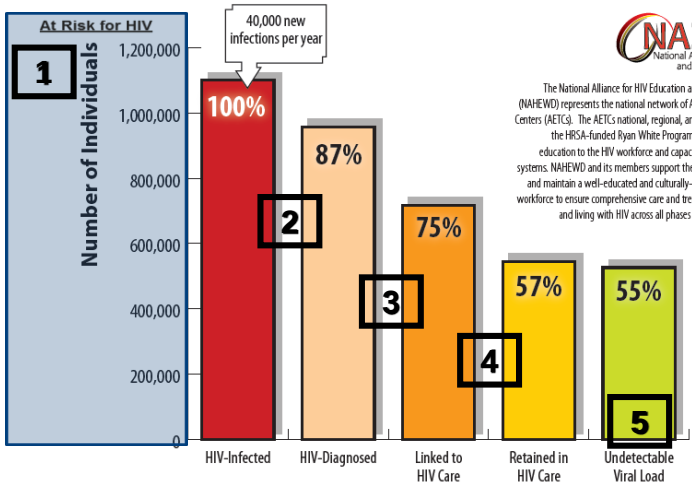
How Viral Load Affects Disease Progression

LEVEL OF VIRAL LOAD (RNA copies per ml)	PERCENTAGE OF DEATHS AFTER...		
	5 Years	7 Years	10 Years
Below 5,300	0%	4.4%	38%
5,300 - 12,900	2%	13%	56%
12,900 - 37,000	10%	63%	71%
Above 37,000	66%	69%	76%

SOURCE: Mallors et al, Quantification of plasmatic HIV-1 RNA predicts the result of HIV infection after seroconversion. Ann. Intern. Med. 1995, 122: 573-579

The U.S. HIV Care Continuum[1]



NAHEWD National Alliance for HIV Education and Workforce Development

The National Alliance for HIV Education and Workforce Development (NAHEWD) represents the national network of AIDS Education and Training Centers (AETCs). The AETCs national, regional, and local centers are a part of the HRSA-funded Ryan White Program. The AETCs provide clinical education to the HIV workforce and capacity-building support to care systems. NAHEWD and its members support the work of the AETCs to build and maintain a well-educated and culturally-sensitive health professions workforce to ensure comprehensive care and treatment to people at-risk for and living with HIV across all phases of the HIV Care Continuum.

1. White House Office of National AIDS Policy. National HIV/AIDS Strategy for the United States: Updated to 2020. Indicator Supplement. Dec 2016. Accessed 1/5/2017: https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-indicators-supplement-dec-2016.pdf

Rev 1-11-17

Where do you see yourself most impacting the HIV epidemic?

1. Identifying those at risk for HIV
2. Testing those at risk for HIV
3. Linking those who have HIV to care
4. Keeping patients in care
5. Improving outcomes for those in HIV care

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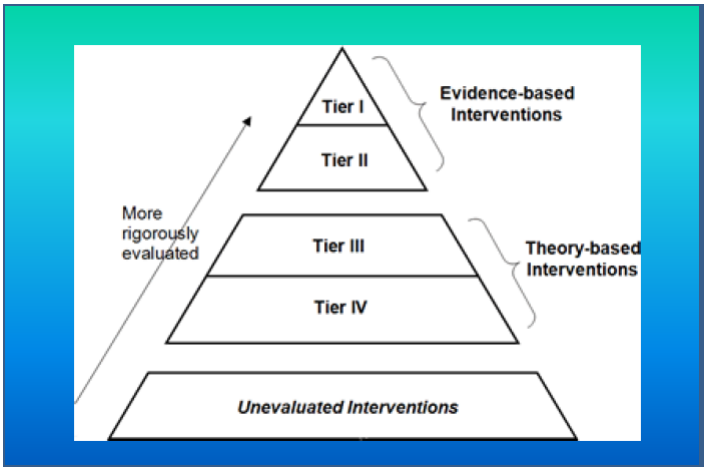
Which best describes your primary work role?

1. Medical Clinician (M.D., NP, Nurse, etc.)
2. Case Manager
3. Substance Use Disorder Treatment Counselor
4. Mental Health Services Provider
5. Administrator, other

CDC Tiers of Evidence Framework



Tiers of Evidence Framework available online: http://www.cdc.gov/hiv/topics/research/prs/tiers-of-evidence.htm#picture

Coping with Hope: Treatment Decisions/Adherence

A Multi-Disciplinary Mental Health Services Curriculum

Funded by SAMHSA Center for Mental Health Services (CMHS)
Mental Health Care Provider Education in HIV (1996/2001)

Why Mental Health Providers (MHP's)?

- *MHP's provide unique skills and settings where clients can discuss challenges and utilize personal behavioral interventions to enhance decision making and adherence*
- *Patients often have more trust and contact with MHP's, who need to know the importance and challenges of HAART*
- *Medical providers are often told "what they want to hear"*
- MHP's may provide a "safer" environment where clients feel comfortable discussing behaviors subject to bias (i.e., use of street drugs, sexual behavior risk, non-adherence to treatment plan)

Common Reasons for Non-adherence

- Forgot to take medication
- Slept through dose
- Away from home/location of medications
- Change in routine
- Substance use
- Feel too sick
- Depression
- Treatment side effects

Common Reasons for Non-adherence
(cont'd)

- Embarrassment
- Overwhelmed by the complexity and frequency of protocol
- Negative beliefs about the efficacy of the recommended course of treatment
- Non-response to treatment
- Lack of emotional support
- Lack of access to basic resources such as transportation problems or an inability to pay for medications
- Social and cultural norms
- Length of treatment

Common Reasons for Non-adherence
(cont'd)

- Patient and family characteristics
- Spiritual, cultural or other strongly-held beliefs about health and treatment
- Maintenance treatment that is long-term and/or prophylactic in nature
- Client appears to be passive recipient of care
- Controlling provider
- Inadequate provider-patient communication
- Inadequate understanding of costs and benefits of treatment
- Non-discussion of potential adherence barriers (i.e., plans for changes in life schedule or medication side effects)

HIV and Adherence Roles for Mental Health Providers

Factors Affecting HIV Adherence
Personal, Provider, Environmental, Systems

Health Belief Model

- History (AZT, "drug holidays")
- Adherence skills
- Substance misuse
- Side effects
  - need to understand, and plan for them
- Environment
  - housing, job, travel

- Understanding Health Care Provider (HCP), regimen
  - Many HCP's do not educate
  - Language/Cultural differences
- Complexity
  - food, water, psychotropic medication
- Availability
  - lack of money, information

HIV and Adherence

What Improves Adherence?

(Reduces Non-adherence)

- Patient's belief in treatment plan
- Patient's understanding of risks/benefits
- When patient understands, help develop skills
- Clinician knows patient's beliefs/skills
- Decreased depression
- Reduced recreational drug use (interactions)
- Social support

HIV and Adherence (cont'd)

Social Support

- Mental health support (disclosure...)
  - And assessment and treatment for depression, anxiety, other
- Involve significant others/family
- Treat for substance use disorders
- Case management/Treatment advocates
- Home visits/follow-ups
- Residential /Board & Care

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HIV and Adherence (cont'd)

Client Education

- Client involvement/sharing is key
- Client must understand his/her readiness
- HIV dynamics
- Purpose of HAART
- All names of each medicine
- Reasons for treatment requirements
- Side effects (prepare, know options)
- Choices (antiretrovirals, etc...)
- Self control of side effects

Health Care Provider Education

- Must know the importance of adherence
- Factors & Frequency of non-adherence
- Destigmatize and address non-adherence (Education reduces bias about non-adherence)
- Techniques for reducing non-adherence
- Examine/enhance communication skills
- Discuss and plan for side effects
- Trust, flexibility, collaborative goal setting
- Involve entire treatment team

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HIV and Adherence for Mental Health Providers

Cues & Reminders

- Outline daily schedule (meals, activities)
- Match treatment plan with habits
- Utilize timed reminders (watch, phone, friend, TV, beepers, timers)
- Use pill boxes, individualized pre-packaging
- Make plan for weekends, holidays, exceptions.

HIV and Adherence

Rewards

- Improved/more stable health/energy
- Fewer medical appointments
- Clinical results (CD4, viral load)
- Achieve other personal goals
- Others?

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HIV and Adherence for Mental Health Providers

Special Considerations for Women

- Best social support is other HIV+ women
- Fewer clinical studies on women and HIV medications
- May have less trust in partner and/or systems
- Family responsibilities – changing routine
- Pregnancy/protecting child(ren) often moving factor
- More likely to share medications, especially with children
- HIV providers and systems often male-oriented
- Substance misuse, depression often untreated
- Women may have more difficulty accessing services

HIV and Adherence for Mental Health Providers

Other considerations?

Helpful hints?

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What is Medication Adherence?

Medication Adherence Is…

The extent to which an individual takes their medications as prescribed by their doctor.

World Health Organization, 2003

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Non-adherence

Medication non-adherence (deliberate or inadvertent) can include:

- Failing to initially fill or refill a prescription
- Discontinuing a medication before the course of therapy is complete
- Taking more or less of a medication than prescribed
- Taking a dose at the wrong time

Why is Adherence to Antiretroviral Therapy (ART) Important?

Sub-optimal ART adherence is strongly associated with treatment failure including:

- Increased mortality
- Viral resistance
- Limited future treatment options
- Increased risk of HIV transmission to others

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Common Measures

- Drug concentrations in blood and urine
- Direct observation
- Pill count
- Self-report
- Monitoring of pharmacy refills
- MEMS – medication-event monitoring system caps on drug bottles

NHAS and Medication Adherence

1. Reducing new HIV infections
2. Increasing access to care and optimizing health outcomes for PLWHA
3. Reducing HIV-related disparities and health inequities

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Medication Adherence Interventions and the Role of HIV Clinicians and SA Providers

Potential future implementers of evidence based medication adherence interventions

CDC Compendium of Evidence-Based HIV Interventions

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Compendium of Evidence-based HIV Behavioral Interventions: I

Risk Reduction Chapter

- EBIs focusing on sex- or drug-related risk behaviors and proven to either reduce HIV or STD incidence or HIV related risk behaviors, or increase HIV risk-reduction behaviors
- 69 RR EBIs identified from the scientific literature published through June 2009
  - 41 **best** evidence
  - 28 **good** evidence
  - 65 individual and group level interventions
  - 5 community level interventions

Compendium of Evidence-based HIV Behavioral Interventions: II

Medication Adherence Chapter

- EBIs focusing on medication adherence behaviors among persons living with HIV and proven to either reduce HIV viral load or improve HIV medication adherence behaviors.
- 8 MA EBIs identified from the scientific literature published or in press from January 1996 through December 2009; updated December 2010
  - 8 **good** evidence interventions
  - 8 individual and group level interventions

Efficacy Review Methods

- HIV Medication Adherence Intervention with
  - Educational / behavioral component OR
  - Treatment delivery methods or monitoring devices to facilitate adherence
- Published or accepted for publication in a peer reviewed journal
- Conducted in the United States or a U.S. territory
- Outcome evaluation report with a comparison arm
- Report any of the following relevant outcome data:
  - Behavioral measures of adherence: EDM (e.g., MEMs caps), pill count, pharmacy refill, self report
  - Biologic measure of adherence: HIV viral load

Efficacy Criteria

- Focus on medication adherence behaviors among persons living with HIV,
- Have been rigorously evaluated, and
- Have shown significant effects in both reducing HIV viral load and improving medication adherence behaviors

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Evidence-Based Medication Adherence Interventions

- ATHENA- Adherence Through Home Education and Nursing Assessment
- DAART- Directly Administered Antiretroviral Therapy for Drug Users
- DAART- Directly Administered Antiretroviral Therapy in Methadone Clinics
- Project HEART- Helping Enhance Adherence to Antiretroviral Therapy
  - Pager Messaging
  - Partnership for Health*
  - Peer Support
- SMART Couples- Sharing Medical Adherence Responsibilities Together

ATHENA

Adherence Through Home Education and Nursing Assessment

- **Target Population**: HIV-positive clinic patients who are antiretroviral treatment-experienced
- **Goal of Intervention**: Improve adherence to antiretroviral therapy
- **Theoretic Basis**: Paolo Freire's educational model
- **Intervention Duration**: 24 home visits on a schedule of declining frequency over 12 months (weekly for 3 months, biweekly for 3 months, and monthly for 6 months)

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ATHENA (cont'd)

Adherence Through Home Education and Nursing Assessment

- **Intervention Settings**: Residence and community settings
- **Deliverer**: Nurse and community/peer worker pair
  Delivery Methods: discussion; drawing and song; goal setting/plan; printed material; problem solving

Reference: Williams, A. B., Fennie, K. P., Bova, C. A., Burgess, J. D., Danvers, K. A., & Dieckhaus, K. D. (2006). Home visits to improve adherence to highly active antiretroviral therapy: A randomized controlled trial. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 42, 314-321.*

ATHENA (cont'd)

Evaluation Study & Results

Adherence Through Home Education and Nursing Assessment

New Haven and Hartford Counties, CT 1999 -2002

Participants (N = 171) - randomly assigned to 1 of 2 groups: ATHENA intervention (n = 87) or usual care comparison (n = 84)

- 42% White 35% African American, 19% Hispanic, 4% Other
- 52% Male, 48% Female

12 months post-initiation of intervention- the proportion of participants who demonstrated >90% adherence, was significantly greater in the intervention arm than in the comparison arm*

- **41%** participants with **>90%** medication adherence measured by MEMS; **70%** participants with **>90%** self-reported medication adherence
- **53%** participants with undetectable viral load (<400 copies/mL)

DAART for Drug Users

Directly Administered Antiretroviral Therapy (DAART) for Drug Users

Target Population: HIV-positive drug-using clinic patients who are antiretroviral treatment-experienced or -naïve

Goals of Intervention

- Improve adherence to antiretroviral therapy
- Reduce HIV viral load
- Increase CD4 cell counts

Intervention Duration: Every week day over 6 months

Intervention Setting: Mobile Community Health Care Van

DAART for Drug Users (cont'd)

Directly Administered Antiretroviral Therapy (DAART) for Drug Users

Deliverer: DAART specialist, who is an outreach worker trained to supervise DAART

Delivery Methods

- directly observed medication administration
- pager reminder

Reference: Altice, F. L., Maru, D. S-R., Bruce, R. D., Springer, S.A., & Friedland, G. H. (2007). Superiority of directly administered antiretroviral therapy over self-administered therapy among HIV-infected drug users: A prospective, randomized, controlled trial. *Clinical Infectious Diseases*, 45, 770-778.

DAART for Drug Users Evaluation

Study & Results *Directly Administered Antiretroviral Therapy (DAART) for Drug Users*

New Haven, CT 2001-2006

Participants (N = 141) were randomly assigned 2:1 to one of two groups: DAART intervention (n = 88) or standard of care comparison (n = 53).

- ***58%** African American, **22%** white, **19%** Hispanic, **1%** Other*
- ***69%** Male, **31%** Female; mean age of 44 years*
- ***88%** treatment-experienced >3 years*
- *36% participants with undetectable viral load (≤ 400 copies/mL)*

At 6 months post-initiation of intervention, a significantly greater proportion of intervention participants achieved virologic success than comparison participants (70.5% vs. 54.7%)

DAART in Methadone Clinics

Directly Administered Antiretroviral Therapy (DAART) in Methadone Clinics

Target Population: HIV-positive injection drug users in treatment who are antiretroviral treatment-experienced or -naïve

Goals of Intervention

- Improve adherence to antiretroviral therapy
- Improve virologic and immunologic responses to antiretroviral therapy (HIV viral load and CD4 cell count)

Intervention Duration: Every morning of methadone clinic visit, over at least one year

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DAART in Methadone Clinics (cont'd)

Directly Administered Antiretroviral Therapy (DAART) in Methadone Clinics

Intervention Setting: Methadone clinic

Deliverer: Nurse or medical assistant

Delivery Methods: Directly observed medication administration

Reference: Lucas, G. M., Mullen, B. A., Weidle, P. J., Hader, S., McCaul, M. E., & Moore, R. D. (2006). Directly administered antiretroviral therapy in methadone clinics is associated with improved HIV treatment outcomes among concurrent comparison groups. *Clinical Infectious Diseases*, 42, 1628-1635.

DAAART in Methadone Clinics (cont'd)

Study & Results ***Directly Administered Antiretroviral Therapy (DAART) in methadone clinics***

Baltimore, MD 2001-2003

Participants (N = 891) were from 1 of 2 groups:

1. DAART Intervention (3 clinics; n = 82 participants) or
2. a non-concurrent comparison (1 clinic; n = 809 participants). Participants ***in Methadone Clinics*** in the non-concurrent comparison were divided into 3 groups based on participant characteristics:
    1. IDU-methadone group [n = 75],
    2. IDU-non-methadone group [n = 244], and
    3. non-IDU group [n = 490])

- **79%** African American,
- **65%** Male, **35%** Female
- Median age of 43 years, range: 38-49
- **27%** treatment-naïve
- **100%** participants with detectable viral load (>500 copies/mL)

Project HEART

Helping Enhance Adherence to antiRetroviral Therapy

Target Population: HIV-positive clinic patients who are antiretroviral treatment-naïve

Goals of Intervention

- Improve initial adherence to antiretroviral therapy
- Improve virologic outcomes (HIV viral load)

Theoretic Basis

- Problem-solving model
- Self-determination theory
- Social support model

Intervention Duration: Five sessions: two 2 – 3 hour sessions just prior to beginning medication; three 1.5 hour sessions (range, 45 minutes to 2 hours) at weeks 2, 4, and 8 following medication initiation, with 5 support phone calls between sessions (weeks 1, 6, and 10 and months 4 and 5 after) and a 1.5 hour booster session at 6 months

Project HEART (cont'd)

Helping Enhance Adherence to antiRetroviral Therapy

Intervention Settings: Public HIV primary care outpatient clinic

Deliverer: nurse interventionist, group discussion facilitator, and access to a peer advocate

Delivery Methods: discussion; individualized adherence plan; practice; video; problem solving

Reference: Koenig, L.J., Pals, S.L., Bush, T., Pratt Palmore, M., Stratford, D., & Ellerbrock, T. V. (2008). Randomized controlled trial of an intervention to prevent adherence failure among HIV-infected patients initiating antiretroviral therapy. *Health Psychology*, 27, 159-169.

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Project HEART Evaluation Study & Results

Helping Enhance Adherence to antiRetroviral Therapy

Atlanta, GA 1999-2002

Participants (N = 236) were randomly assigned to 1 of 2 groups: HEART Intervention (n = 116) or enhanced standard of care (n = 120).

- ***83%** African American, **12%** white, **3%** Other, 2% Hispanic*
- ***64%** Male, **36%** Female*
- ***58%** heterosexual, **32%** gay or lesbian, **8%** were bisexual, **1%** undecided*
- *Median age of 37 years, range: 31-43 years*
- ***100%** treatment-naïve with detectable viral load (>400 copies/mL)*

At 3-months post-initiation of intervention, a significantly greater proportion of intervention participants achieved ≥ 90% adherence, as assessed by MEMs caps, than comparison participants (46% vs. 28%)*

Pager Messaging

Target Population: HIV-positive clinic patients who are antiretroviral treatment-experienced or - naïve

Goals of Intervention

- Improve adherence to antiretroviral therapy
- Improve clinical outcomes (HIV viral load and CD4 cell count)

Intervention Duration: daily customized pager messages over 3 months

Intervention Setting(s): anywhere the patient has access to their pager

Deliverer: 2-way pager

Delivery Method(s): pager reminder; text messages

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Pager Messaging Study & Results

Seattle, WA 2003-2007

Participants (N = 226) were randomly assigned to 1 of 4 groups:

1. Peer support only (n= 57)
2. Pager messaging only (n = 56)
3. Peer support & pager messaging (n= 56)
4. Usual care (n = 57)
   - ***47%** White, **30%** African American, **12%** "other" or "mixed" race, **11%** Hispanic*
   - ***76%** Male, **24%** Female*
   - *Mean age of 40 years, range: 19-60 years*
   - *62% treatment-naïve, 38% switching or restarting treatment*
   - *Mean viral load*

Pager Messaging Study & Results (cont'd)

- Across all three assessment time points, participants in the pager messaging intervention arms (i.e., pager messaging only and pager messaging with peer support) were significantly more likely than participants in the comparison without pager messaging to achieve an undetectable viral load

Reference: Simoni, J. M., Huh, D., Frick, P. A., Pearson, C. R., Andrasik, M. P., Dunbar, P. J., & Hooton, T. M. (2009). Peer support and pager messaging to promote antiretroviral modifying therapy in Seattle: A randomized controlled trial. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 52, 465-473.

Peer Support

Target Population: HIV-positive clinic patients who are antiretroviral treatment-experienced or -naïve

Goals of Intervention

- Improve adherence to antiretroviral therapy
- Improve clinical outcomes (HIV viral load and CD4 cell count)

Theoretic Basis

- Social cognitive theory
- Social support theory

Intervention Duration: six twice-monthly 1- hour group meetings and weekly phone calls over 3 months

Peer Support (cont'd)

Intervention Setting: public HIV primary care outpatient clinic

Deliverer: peer and research staff

Delivery Methods: Group discussion; pager reminder; phone calls

Reference: Simoni, J. M., Huh, D., Frick, P. A., Pearson, C. R., Andrasik, M. P., Dunbar, P. J., & Hooton, T. M. (2009). Peer support and pager messaging to promote antiretroviral modifying therapy in Seattle: A randomized controlled trial. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 52, 465-473.

Peer Support Study & Results

Seattle, WA 2003-2007

Participants (N=226) were randomly assigned to 1 of 4 groups:

1. Peer support only (n= 57),
2. Pager messaging only (n = 56),
3. Peer support & pager messaging (n= 56), or
4. Usual care (n = 57) 226 men (76% male) and women (24% female):
   - ***47%** White, **30%** African American, **12%** "other" or "mixed" race, **11%** Hispanic*
   - *Mean age of 40 years, range: 19-60 years*
   - ***62%** treatment-naïve, **38%** switching or restarting treatment*
   - *Mean viral load = 25,000, range: 1,250-500,000*

Participants in the peer support intervention arms (i.e., peer support only and peer support with pager messaging) were significantly more likely than participants in the comparison without peer support to report 100% adherence over time between baseline and 3 months post-initiation of intervention

Partnership for Health

Target Population: HIV-positive clinic patients who are antiretroviral treatment-experienced

Goals of Intervention

- Improve adherence to antiretroviral therapy
- Achieve undetectable viral load

Theoretic Basis: Mutual participation model of patient care

Intervention Duration: A 3- to 5-minute session at each clinic visit over 10 to 11 months

Intervention Settings: HIV primary care outpatient clinics

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SMART Couples

Sharing Medical Adherence Responsibilities Together

Target Population: heterosexual and homosexual HIV-serodiscordant couples, with poor medication adherence in the HIV-positive partner

Goals of Intervention

- Improve adherence to antiretroviral therapy
- Increase social support for adherence to antiretroviral therapy and risk reduction
- Address couple's sexual transmission concerns
- Address couple's issues of sex and intimacy

Theoretic Basis: Ewart's social action theory and self-regulation theory

SMART Couples (cont'd)

Sharing Medical Adherence Responsibilities Together

Intervention Duration: Four 45-60 minute sessions over 5 weeks

Intervention Settings: Public and private HIV outpatient clinics

Deliverer: Nurse practitioner

Delivery Methods: exercise; discussion; instruction lecture/teach; problem solving

Reference: Remien, R. H., Stirratt, M. J., Dolezal, C., Dognin, J. S., Wagner, G. J., Carballo-Dieguez, A., Jung, T. M.(2005). Couple-focused support to improve HIV medication adherence: *A randomized controlled trial. AIDS*, *19*, 807-814

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SMART Couples Evaluation Study & Results

Sharing Medical Adherence Responsibilities Together

New York City, NY 2000-2004

Couples (N = 215) were randomly assigned to 1 of 2 groups:

- SMART couples (n= 106) or
- usual care (n = 109)

215 HIV-positive partners of serodiscordant couples is characterized by the following:

- ***62%** African American, **24%** Latino*
- ***54%** Male, **46%** Female*
- ***74%** heterosexual couples, **26%** homosexual couples*
- *Mean age of 42 years • **100%** treatment-experienced*
- ***100%** missed > **80%** prescribed doses in past 2 weeks (MEMS)*
- ***41%** participants with undetectable viral load (level not defined)*

Evidence-Based Medication Adherence Interventions

- **ATHENA-** Adherence Through Home Education and Nursing Assessment
- **DAART-** Directly Administered Antiretroviral Therapy for Drug Users
- **DAART-** Directly Administered Antiretroviral Therapy in Methadone Clinics
- **Project HEART-** Helping Enhance Adherence to antiRetroviral Therapy
  - Pager Messaging
  - Partnership for Health*
  - Peer Support
- **SMART Couples-** Sharing Medical Adherence Responsibilities Together

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More detailed information can be found here:

Interventions addressing medication adherence
https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/BiomedicalInterventions/MedicationAdherence.aspx

References

• Center for Disease Control and Prevention (CDC). Compendium of Evidence-Based HIV Behavioral Interventions. https://effectiveinterventions.cdc.gov/

• Rhodes, S.D, Hergenrather, K. C., Wilkin, A.M., Wooldredge, R. (2008). Adherence and HIV: a lifetime commitment. In Shumaker, S. A., Ockene, J. K., & Riekert, K. A.(Eds.), The handbook of health behavior change (pp. 659-675), New York, NY: Springer Publishing Company.

• Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy (OHAIDP), National HIV/AIDS Strategy for the United States. https://www.aids.gov/federal-resources/national-hiv-aids-strategy/overview/

• World Health Organization (WHO). Adherence to Long- Term Therapies: Evidence for Action. 2003. http://www.who.int/chp/knowledge/publications/adherence_report/en/index.html

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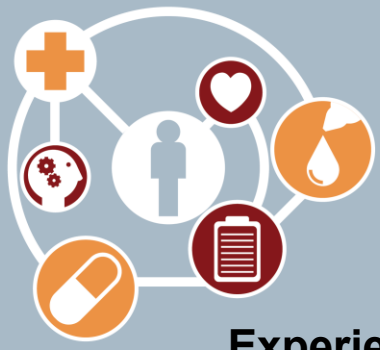

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CENTER for INTEGRATED
HEALTH SOLUTIONS

Experiences from the field….

Nicole Proviano, R.N., M.S.
Director of Nursing
MAI-CoC: Project Cope
Brandywine Counseling and Community Services
Wilmington, DE

Brandywine Counseling & Community Services

- Primary location: Wilmington, Delaware
  Satellite locations throughout the state
- Provider of mental and substance use disorder treatment for 25 years
- Wilmington and Newark - Medication Assisted Treatment (MAT) locations serve close to 2,000 clients
- Provide methadone, suboxone and Vivitrol as well as drug-free programs

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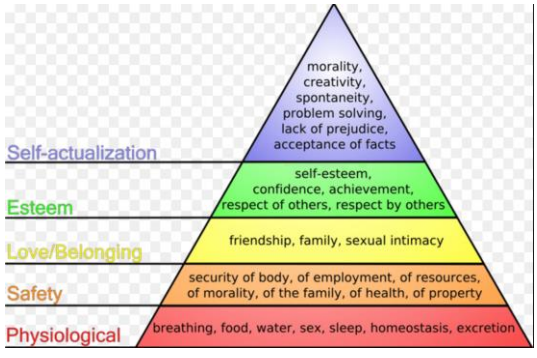
Brandywine Counseling & Community Services (BCCS)

Provision of wrap-around services

Programming possible through federal and state grant funding/allocations and community partnerships

- Infectious disease clinic on site
- Drop-In center
- Syringe exchange
- Perinatal program
- Mobile outreach
- Adolescent programming
- Prevention services

Maslow's Hierarchy of Needs



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Competing Priorities

- Where is the patient on the hierarchy?
- Difficult to promote health maintenance when basic needs not met
- Demands of employment, family and even treatment

Co-located HIV Clinic

- Collaboration with Christiana Care Health System
- Nurse Practitioner on-site 4 days/week
- M.D., Social Worker, phlebotomist weekly
- Referrals to clinic from sources throughout BCCS

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Advantages in MAT Programs

- Clients motivated to come in daily for MAT
- Co-located clinic convenient for care
- Frequent observation of client
- Wrap around services

Medication Adherence Roles

Importance of adherence education across specialties

View all Points-of-Contact as potential opportunities

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Evidenced-Based Practices

Motivational Interviewing
www.motivationalinterviewing.org

Screening, Brief Interventions & Referral to Treatment (SBIRT)
www.sbirttraining.com

THANK YOU!

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Questions?

Enter your questions into the Questions box for the presenter to respond in discussion

Next Webinar

Tuesday, May 2, 2017

Provider Communication: Talking about Sexual Health for People at Risk, and Living with HIV

MAI-CoC Communities of Practice

- **Keys to Developing an Effective Syringe Service Program and other Related Evidence Based Practices and Partnerships to Enhance the MAI-CoC**

  Session Dates: **Wednesday 4/26 at 2:00pm ET**

- **Sharing Integration Innovations (e.g., PrEP, PeP, MAT). What works, what doesn't work?**

  Session Dates: **Thursday 4/27 at 3:00pm ET**

Learn more and register at:

http://www.integration.samhsa.gov/mai-coc-grantees-online-community/communities-of-practice

integration.samhsa.gov

Onsite Trainings for MAI-CoC Grantees

- Motivational Interviewing
- Using GPRA/TRAC Data for Program Sustainability
- Trauma-Informed Care
- Whole Health Action Management
- SBIRT
- Integrated Practice Assessment Tool (IPAT) Consultation and Planning
- Medication Assisted Treatment 101
- Achieving Cultural Competence in Behavioral Health and HIV Service Delivery
- Case Management to Care Management Training
- Mastering Supervision
- Staff Wellness

https://form.jotform.com/63356260032952

Contact: integration@thenationalcouncil.org

integration.samhsa.gov

For More Information & Resources

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e-mail integration@thenationalcouncil.org

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Please take a moment to provide your feedback by completing the survey at the end of today's webinar.

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